

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1095	Date: OCTOBER 27, 2006
	Change Request 4276

SUBJECT: Processing All Diagnosis Codes Reported on Claims Submitted to Carriers

I. SUMMARY OF CHANGES: CMS is requiring that all standard systems for carrier claims process all diagnosis codes reported in the adjudication of the claim. This CR will be implemented in multiple phases. The first phase included the analysis and design. This is the second phase, which includes finalization of the requirements and coding development.

New / Revised Material

Effective Date: April 1, 2007

Implementation Date: April 2, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Recurring Update Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1095	Date: October 27, 2006	Change Request 4276
-------------	-------------------	------------------------	---------------------

SUBJECT: Processing All Diagnosis Codes Reported on Claims Submitted to Carriers

Effective Date: April 1, 2007

Implementation Date: April 2, 2007

I. GENERAL INFORMATION

A. Background:

The ANSI 837P 4010A allows a maximum of eight diagnosis codes to be reported for each claim. In processing the HIPAA format claim, the Multi-Carrier System (MCS) applies the first four diagnosis codes on the claim. The remaining diagnosis codes are not used in the payment determination for Medicare.

The clinical laboratory negotiated rulemaking committee agreed that Medicare will consider all diagnosis codes reported in the processing of claims for clinical laboratory services. Heretofore, the enforcement of this requirement was generally done manually. This process has not always worked effectively and many times claim development is initiated when the proper diagnosis had already been reported on the initial claim. This change request implements the Negotiated Rulemaking agreement to automatically consider all diagnosis codes reported.

This CR will also require the MCS to process all diagnosis information submitted on the approved HIPAA claim format for all other types of claims. The purpose of this instruction is to implement requirements in the carrier standard system that all diagnosis codes reported on **any** claim are processed in the carrier standard system up to the maximum allowed by the ANSI 837P 4010A1 claim format. Generally, paper claims should have only four diagnoses. If more are reported, MCS should capture up to the maximum allowed by the ANSI 837 4010A1 claim format. This CR will also implement requirements to pass this information to the CWF for processing and the National Claims History (NCH) for storage.

This CR is being implemented in multiple phases. The first phase, which included the analysis and design, was implemented in the April 2006 standard system release. (See CR 4097, Transmittal 735, issued on October 31, 2005.) This CR is the second phase of the implementation, which becomes effective on April 1, 2007 and includes finalization of the requirements and coding development. The final CR, tentatively scheduled to be implemented on July 1, 2007, will include requirements for documentation and testing. The changes specified in this CR will become operational when the final phase of implementation is completed in the July 2007 (tentative date) standard system release.

B. Policy:

Effective for claims processed July 1, 2007 and later (tentative date), the carrier standard system shall capture and process up to eight diagnosis codes reported on a claim. Effective for claims processed July 1, 2007 and later, the Common Working File (CWF) shall accept all diagnosis codes reported by the MCS to CWF. Within 45 days of the implementation of the coding

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B	D M E	F I	C A R R I E R	D M R C	R H H I	Shared-System Maintainers				OTHER
		M A C	M A C					F I S S	M C S	V M S	C W F	
4276.8	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.				X							

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
4276.1-4276.7	Implement in accordance with CR 4097.

B. For all other recommendations and supporting information, use the space below: N/A

V. CONTACTS

Pre-Implementation Contact(s): Susan Webster, (410) 786-3384, susan.webster@cms.hhs.gov

Post-Implementation Contact(s): Susan Webster, (410) 786-3384,
susan.webster@cms.hhs.gov

VI. FUNDING

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.